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Abstract

Background: Pakistan has one of the highest maternal mortality rates in the world. Community Midwives (CMWs) were introduced in 2006 as a new cadre of birth attendants who would bring midwifery services to rural areas by being based in designated communities. The CMWs face many obstacles and retaining them in practice is a challenge. This study aimed to examine whether there was a relationship between family support and CMWs retention in midwifery practice. We hoped to learn about influences on retention that might improve the Maternal Newborn and Child Health (MNCH) programme.

Methods: This was a cross-sectional survey conducted in five districts of rural Sindh, a province in Pakistan. A list of all CMWs who graduated between 2007 and 2012 was obtained from the MNCH programme Sindh. The CMWs were tracked by MCHIP (Maternal Child Health Integrated Program) clinical supervisors posted in the respective districts to gather information about families' support of CMWs.

Findings: Of the 148 CMWs in the MNCH list, 112 (76%) were tracked. Of 112, 44 (39%) CMWs were in active practice while 69 (61%) had completed their training but had not started a practice. Of the 44 practising CMWs, 82% had family members who worked in a health-related field or previously were traditional birth attendants (TBAs). Only 18% of those who established a practice had a family without this profile.

Conclusion: These preliminary findings indicate a strong relationship between family engagement in health care work and the capacity of CMWs to establish a midwifery practice. A further comparative analysis of practising and non-practising CMWs is warranted.

Key words: *Community midwife, retention, midwifery practice, family support, CMW Pakistan*

Introduction

Pakistan has one of the highest maternal mortality rates (MMR) in the world. The country has shown very little improvement in the health status of its population and is lagging far behind its immediate neighbours (except Afghanistan) in terms of health and social indicators. Of concern is the lack of progress in maternal and child health.[1] The health indicators are unacceptably high, such as MMR 276/100,000 live births, infant mortality (86 per 1,000 live births).[2] The Government of Pakistan has initiated several maternal, newborn, and child health (MNCH) and family planning (FP) programmes to improve the health of families in Pakistan. As a result, some figures are improving such as 52% of births are now assisted by a skilled birth attendant.[3] However, the institutional delivery rate is low and the majority of women prefer to deliver at home with a TBA (traditional birth attendant).[3]

Pakistan is listed amongst the nations with a critical health workforce deficiency.[4] According to the World Health Organization (WHO) a physician-based model is inaccessible to most of the population in middle- and low-income countries. Most women from rural Pakistan have no access to health facilities because they are located in distant urban centers and are not affordable even if they could be reached.[5]

The programmes to prepare Community Midwives (CMWs) were introduced nationally in 2006 through the Maternal Newborn and Child Health (MNCH) Program to provide a new

cadre of birth attendants with the aim of improving access to midwifery services by placing CMWs closer to the women and families in rural areas. The plan was to select young women with a tenth -grade pass from rural communities who would receive 18 months of midwifery education and return to their own communities to provide midwifery services. By July 2014, 12,270 CMWs had enrolled and 8,887 had successfully completed their training. MNCH's strategic plan was intended to scale-up the CMW programme as a means of delivering quality health services through development of a competent workforce.[6]

Pakistan continues to face a huge challenge in providing sufficient skilled midwifery services to meet the sexual and reproductive health (SRH) needs of women and adolescent girls. Among the existing mid-level health workers (nurses, midwives, Lady Health Visitors), only 2.2% are CMWs.[8] Investment in CMWs was thought to be important because they are posted in rural, hard-to-reach areas where they may be the only SRH provider. Their provision of good quality primary care services in rural areas could improve health outcomes by preventing some problems and enabling specialists to provide better coverage of complex health problems.[8-9] However, like many new initiatives, the CMWs faced challenges. It is apparent now, 12 years after its inception, that there is a high level of doubt about the sustainability of the programme. Research published in 2015 from Punjab province showed that 16% of CMW graduates had never conducted a delivery independently in hospitals, and 46% had never conducted a delivery independently in the community.[90] These results were markedly different from what had been expected. Planners thought that deployment to a setting upon completion of the CMW programme with two years of financial and supervisory support (through a mandatory bond period), would lead to viable independent practice and bring significant reductions in maternal and child mortality.

The biggest challenge faced by the programme was sustainability of the trained CMWs in the field beyond the two-year bond period. Significant proportions of CMWs discontinued their services and were lost to the health care network. Findings from studies identified reasons the CMWs discontinued their work.[10] One study revealed that CMWs are "struggling for survival" as qualified home based maternal health care providers. The lack of a support system is evident by the lack of provision of appropriate equipment; minimal financial and logistics support from the health department, and lack of facilitation from LHWs and untrained TBAs.[11] There was

little or no information about whether family characteristics/family support had an impact on the ability to practise.

Research Question

The purpose of this study was to identify whether there is a relationship between family supports and CMW retention in midwifery practice. Knowledge of such factors could assist in making recommendations to the MNCH programme about the CMW workforce.

Methods

Study Design and Setting

A cross-sectional survey was carried out in Sindh province, Pakistan, to examine factors related to retention of CMWs in practice. A list of CMWs who had completed their study between 2007 and 2012 was obtained from the MNCH Program. From the list it was possible to track CMWs to their communities and assess family supports and whether they were providing services.

Data Collection Methods

Clinical Supervisors from the Maternal Child Health Integrated Program (MCHIP) who were based in the selected rural districts were trained as data collectors by a specialized team. Following the training, each supervisor met with CMWs and their families to verify how many were offering services and to inquire about family members' occupations using a standardized questionnaire.

Data Collection Tool

The questionnaire was developed by the MCHIP technical team; it included demographic data and a family profile. The questionnaire started with a detailed interview guide for the data collectors. After pre-testing in one of the districts, some modifications were made.

Data Analysis

Initially, data was entered in an Excel data file and then imported into SPSS software version 20. All variables were re-coded in SPSS data file for analysis. Frequency distributions of socioeconomic variables and family member's occupations were done.

In this paper we report only the relationship of family member's occupations with CMW's retention in practice. Other dimension of family support was not measured and hence, is a limitation of this study.

Results/Findings

Of 148 CMWs who were in the MNCH list, 112 (76%) were located. Among them only 44 (39%) were professionally active and were practising in their designated communities. The remaining CMWs were "pre-active" meaning they had completed their pre-service training but had not initiated their practice. Of the 44 in active practice, 36 (82%) had family members working in a health-related field or themselves had been a TBA. The remaining eight CMWs with an established practice had no family members in a health related field.

When the details of family members' work were examined there were numerous roles held: previously being a TBA (n=2), having a mother or close relative as a TBAs (6); doctors (8), Nurse/Lady Health Visitor (5), midwife (4) and Lady Health Worker/Lady Health Supervisor (10). The data showed that relatives of the 68 pre-active CMWs were not in a health-related job. None of that group had previously been a TBA or was a relative of a TBA.

When the data were examined for each district, the pattern was the same. Details are given in Table 1 below.

Discussion

The data drawn from five different districts in rural Sindh allow for comparisons in examining the factors that influence CMWs to remain in practice. Those who were a TBA before completing a CMW programme and/or had close family members in a health related field were far more likely to be in practice compared to those without relatives in a health related field. Having family members who are knowledgeable about health care and who have links to

networks of providers may be crucial for CMWs being able to sustain a practice, especially if the family members are already well respected within the local community.

Novice CMWs need guidance and support from family members to organize and establish their practice. A study conducted in Punjab showed similar findings "All the successful CMWs had, without exception, support from family members to work as midwives. Family support to work, especially in an occupation requiring door-door travel, often at night, is crucial for CMWs to practice."[12] Perhaps the other critical piece may be a familiarity with the medical environment and medical care that makes the prospect of independent private practice less intimidating.

According to a USAID policy brief, "Although the programme has proved to be quite successful in countries like Indonesia and Malaysia, there are several implementation issues that were experienced with the program in Pakistan."[13] Research showed that the community members were unaware of the availability and purpose of CMWs. This is due to ineffective communication strategies and the non-engagement with the community at the time of deployment.[14] Therefore, when family members could introduce the CMW to the community and provide continuous support for practical challenges, the CMW was more likely to succeed.

If CMWs are to be an effective provider of maternity care for a large proportion of births in Pakistan, there must be attention paid to the factors that will keep them in practice. The association of family members' experience with health care and retention of CMWs in practice may have to do with practical support, but the family link may also facilitate those midwives to more easily become part of a team and referral network, both of which are essential to high quality care. This lesson was clearly revealed in the conclusions of *The Lancet* Midwifery Series 2014 that found midwifery was associated with more efficient use of resources and improved outcomes when provided by midwives who were educated, trained, licensed, and regulated, and were most effective when integrated into the health system in the context of effective teamwork and referral mechanisms and sufficient resources.[15]

Table 1

District	Number of CMWs on MNCH list	Total Tracked n (%)	Practising (Active) n (%)	Non-Practising (Pre-active) n(%)	Active CMWs with health related background n(%)	Active CMWs with non-health related background n(%)
Khairpur	38	23(61)	10(43)	13(57)	07(70)	3(30)
Dadu	28	25(89)	11(44)	14(56)	11(100)	0(0)
Tando Allahyar	28	20(71)	5(25)	15(75)	4(80)	1(20)
Tharparkar	23	22(96)	07(32)	15(68)	7(100)	0(0)
Thatta	31	22(71)	11(50)	11(50)	7(64)	4(36)
Total	148	112(76)	44(39)	68(61)	36(82)	8(18)

Implications and Recommendations

The findings of the study have implications for retaining CMWs in practice in Pakistan. CMWs who have previous experience as a TBA or who have family members working in health care are more likely to establish practice after their training. However, there were individuals without such family supports who were also successful. Programmes should consider the background and family supports of candidates at the time of selection. Those who previously were TBAs or have relatives who are TBAs or other health providers may have a greater likelihood of establishing and maintaining a practice. For those without such family supports, MNCH or other groups need to consider how to provide greater mentoring to facilitate their likelihood of success.

Further study of factors that can increase retention is important since family support is only one aspect of a complex picture. If the CMW programme is to be successful in improving maternal and child health in the country, continued attention to the education, regulation, sufficient resources and effective integration of this provider group is necessary.

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